MULTI-SECTORAL NEEDS ASSESSMENT

Dadaab refugee complex, Garissa County, Kenya.

December 2021

BACKGROUND

As of October 2021, a total of 232,903 refugees and asylum seekers resided in Dadaab Refugee Complex (Dagahaley, Hagadera and Ifo refugee camps). Since May 2017, REACH initiative has worked in collaboration with the Norwegian Refugee Council (NRC), the United Nations High Commissioner for Refugees (UNHCR) and other relevant humanitarian actors in Dadaab to conduct joint multi sectoral needs assessments (MSNAs).

Continued conflict, instability, and drought conditions continue to cause new displacement in Somalia and into Kenya, while humanitarian funding has reduced in Dadaab. All the while, the COVID-19 pandemic is still ongoing, and its impact is being felt across many sectors in the country. As of November 30, 2021, a total of 255,088 persons had been tested positive for COVID-19 since the start of the pandemic and only 9.9% of the adult population was fully vaccinated. The COVID-19 situation, alongside discussions around camp closure among the Kenyan government in March 2021, creates the need to update the available information on humanitarian needs and access to assistance and services in the camps. Such information is needed to support evidence-based planning of the immediate refugee response and further inform the development of longer-term response strategies.

This situation overview presents findings of a multi-sector needs assessment conducted in November 2021. Similar assessments were conducted in October 2020, September 2019, February 2019 and December 2018 across the three camps of Dadaab refugee complex. It provides an analysis of needs across the following sectors; education, protection, food security, health and nutrition, water, sanitation and hygiene (WASH) and livelihoods, and provides a trend analysis of some key indicators over the period from December 2018 to November 2021.

METHODOLOGY

REACH conducted the assessment through household (HH) level interviews and key informant interviews (KIIs). HH interviews were conducted from 3 to 15 November 2021 with a total of 1186 HHs from the three camps (395 in Dagahaley, 389 in Hagadera, 402 in Ifo). A total of 30 KIIs were conducted between 3 and 15 November with leaders of various groups in the camps. (see table 1 and 2 below for sample breakdown)

The sample for HH interviews was selected through probability stratified random sampling at individual camp level to fulfill a 95% confidence level and 5% margin of error and was calculated based on the HH population of each camp. A 5% buffer was included at camp level to account for deleted surveys. The confidence level is guaranteed for all questions that apply to the entire surveyed population of each camp. Findings relating to a subset of the surveyed population may have a wider margin of error and a lower confidence level. The data was weighted during analysis to account for lack of proportionality for individual camp samples.

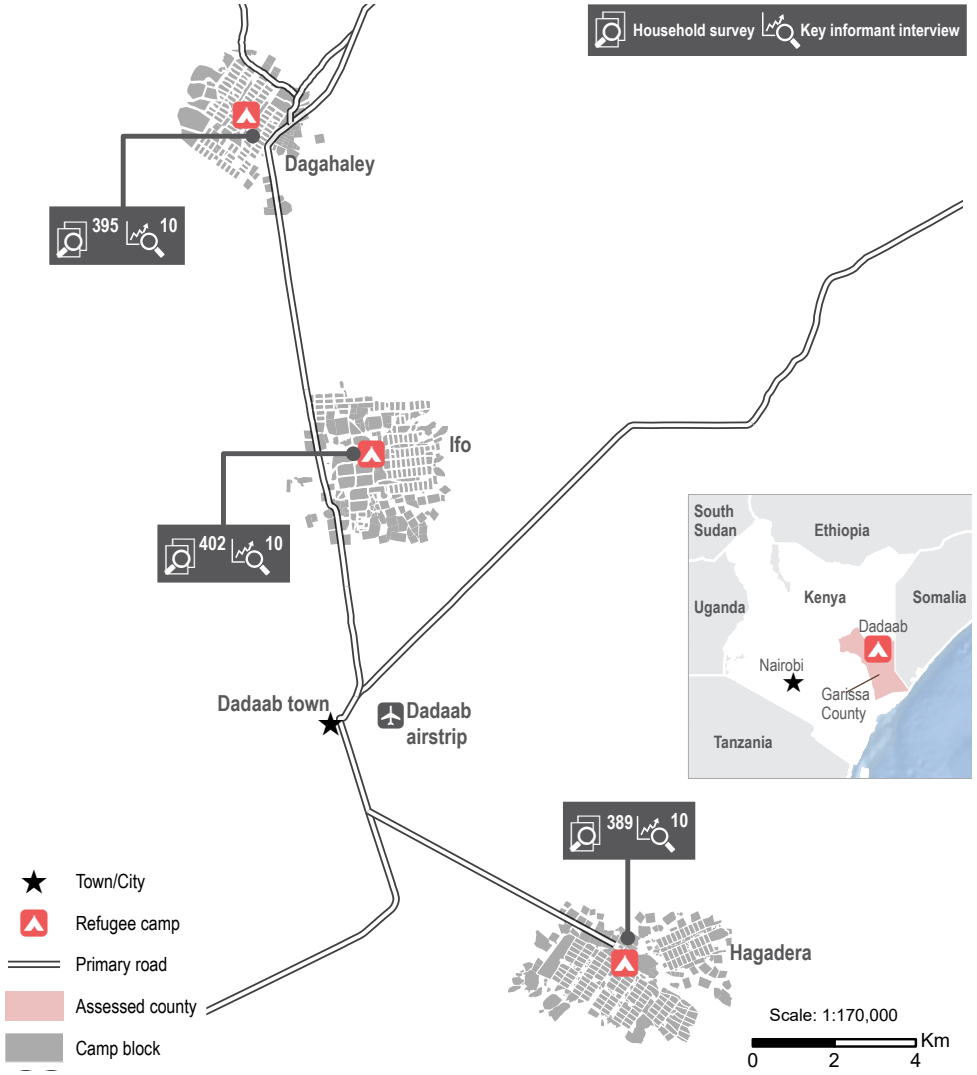
Table1: HH sample

Camp	Total HHs	Sample size
Dagahaley	14,903	395
Hagadera	17,314	389
Ifo	14,492	402
Total	**46,709**	**1,186**

Table 2: KIs sample

Community leader group	Dagahaley	Hagadera	Ifo	Total KIs
Camp leaders	2	2	2	6
Youth leaders	2	2	2	6
Leaders of persons living with disabilities	2	2	2	6
Minority group leaders	2	2	2	6
Older persons' leaders	2	2	2	6
Total				**30**

LOCATIONS OF DATA COLLECTION



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KEY FINDINGS

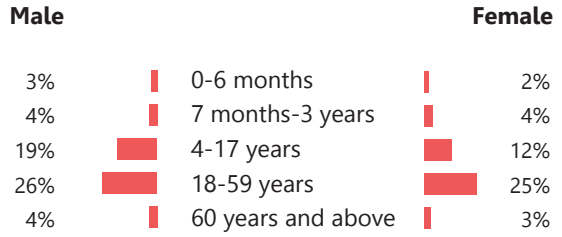
- Findings indicate that HHs in Dadaab refugee complex have various needs across multiple sectors. Despite receiving humanitarian assistance, food security was found to be one of the most persistent challenges that most HHs were facing. **Fifty-nine percent (59%) of HHs were found to have either a poor or borderline food consumption score (FCS) and 54% of HHs were using either emergency, crisis, or stress level livelihood-based coping strategies**, which indicates that their FCS would be lower were they not engaging in these unsustainable coping strategies. **Among the 78% of HHs that had reportedly borrowed money to meet their needs, 87% reported having spent it on food.** In November 2021, almost all **HHs (98%) reported food to be among their priority needs**, similar to the proportion of HHs reporting food to be a priority need during all previous rounds of the MSNA from December 2018 through October 2020 (over 95% in all rounds).
- All HHs (100%) reported having received humanitarian assistance in the three months prior to data collection. Moreover, **76% of HHs reporting having received food voucher assistance** in the three months prior to data collection.
- Overall, the **majority (81%) of HHs reported that the number of people they identified as part of their HHs were all registered either as refugees or asylums seekers**. A high proportion (87%) of the unregistered HH members were found to have stayed in Dadaad for less than 2 years. Furthermore, about half of the HHs in Dadaab refugee complex reported that members of their HHs had lived in their camps for over 15 years. Moreover, majority (97%) of HHs reported that members of their HHs possessed refugee alien cards.
- Generally, the majority of HHs in Dagahaley (73%), Hagadera (81%), and Ifo (69%) reported perceiving the security situation within their camps to be very good. However, **a high proportion of HHs (84%) reported that women and girls felt unsafe while collecting firewood**, which was also found to be the **major source of energy for cooking for a majority of HHs (92%).**
- Sixty nine percent (69%) and 48% of HHs reported that community members most commonly report security concerns to **community leaders or the police** respectively. In addition, the majority of HHs (77%) reported perceiving that it **generally takes less than a month for security providers to resolve insecurity cases**.
- Generally, access to sanitation services in Dadaab refugee camps was seemingly good at the time of data collection. Almost all HHs (98%) reported having access to a sanitation facility. However, a considerable proportion of HHs (61%) reported experiencing challenges related to accessing sanitation facilities. KIs reported that the community used sanitation facilities that **were not segregated by gender, did not have privacy, were unclean, and overcrowded, hence exposing them to risk of contracting diseases.**
- HH members reported to having experienced different livelihood barriers due to the impact of COVID-19. Some of the barriers that HH members most commonly reported include; **increased prices of commodities (40%), reduced income among HH members (25%) or at least one HH member losing their job as a result of COVID-19 related challenges (18%).**
- Forty-three percent of HHs (43%) reported having **at least one member of their HH operating a business in Dadaab.** However, KIs reported that business owners often **lack access to loans** and **funds to restock their business** and that there are particular **laws that are unfavourable for businesses.**
- Among all school-aged boys and girls in the assessed HHs, **a higher proportion of boys (51%) and girls (57%) in Ifo than in Dagahaley and Hagadera were reportedly not attending school** in the 12 months prior to data collection.

DEMOGRAPHICS

The majority of HH survey respondents were female (52%), and almost all respondents (88%) were younger than 60 years. The population pyramid below shows the aggregated demographics for all the three camps. The results indicate that Dadaab's population pyramid is skewed towards the younger segments of the population, with a higher proportion of HH members being adults between the ages of 18 and 59, followed by those under the age of 18, and a minority of HH members aged 60 or older.

The average household was found to consist of six members, three of whom were younger than 18 years old on average.

Figure 1: Proportion of HH members by age and gender



About sixty percent (60%) of HHs were reportedly female-headed. This proportion appeared similar, albeit slightly higher, compared to the proportion of female-headed HHs found in previous rounds of the assessment in October 2020 (58%), September 2019 (56%) and February 2019 (57%).

In November 2021, the majority of HHs in Dadaab refugee complex reported that their country of origin was Somalia, down from 98% in the previous round in October 2020. Nine percent (9%) of HHs reported their head of HHs' origin was from Ethiopia, indicating a slight shift in displacement patterns.

Half (50%) of HHs had reportedly lived in Dadaab refugee complex for more than 15 years.

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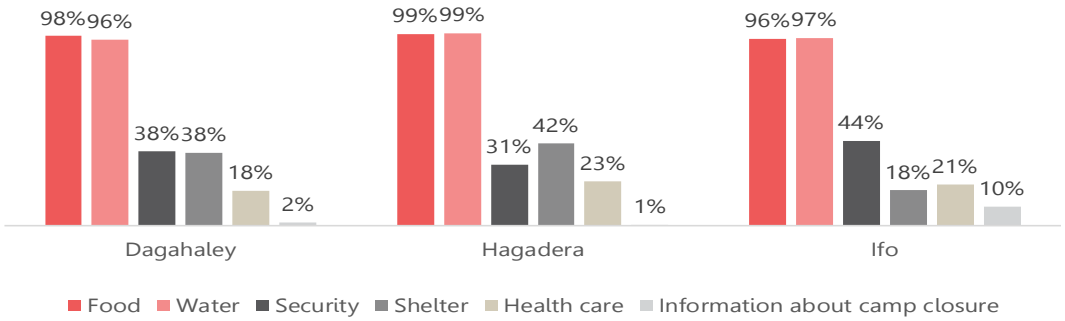
HUMANITARIAN ASSISTANCE

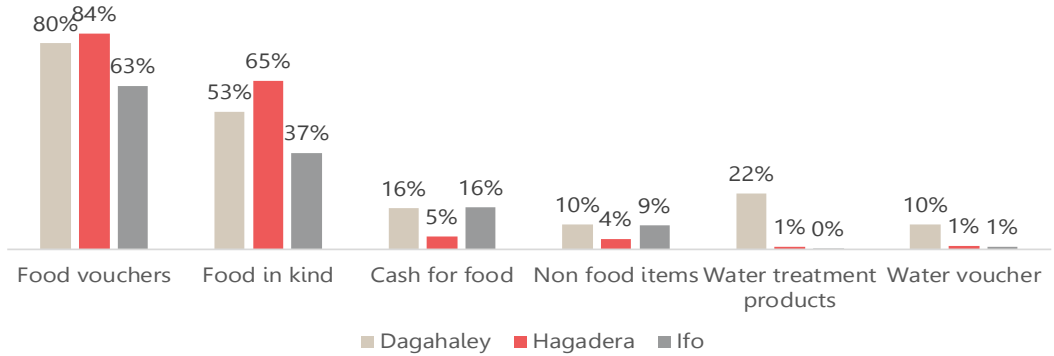
Findings indicate that food security has remained a priority need for HHs in Dadaab Refugee Complex throughout the past years, with over 95% of HHs reporting this in each round of the REACH multi-sector needs assessment in Dadaab from December 2018 to the current round (November 2021). Despite a considerable proportion of HHs (76%) reporting having received food voucher assistance in the three months prior to data collection, 98% of HHs reported food as one of their top three priority needs.

Figure 3: Most commonly reported top 3 HH priority needs in the 30 days prior to data collection[2]:



All HHs (100%) reported having received humanitarian assistance in the three months prior to data collection. Of these, 14% of HHs in Ifo, 8% in Hagadera and 13% in Dagahaley reported not being satisfied with the assistance received mainly because it was not enough. In the three months prior to data collection, the most commonly reported assistance received by HHs across the three camps was food voucher assistance.

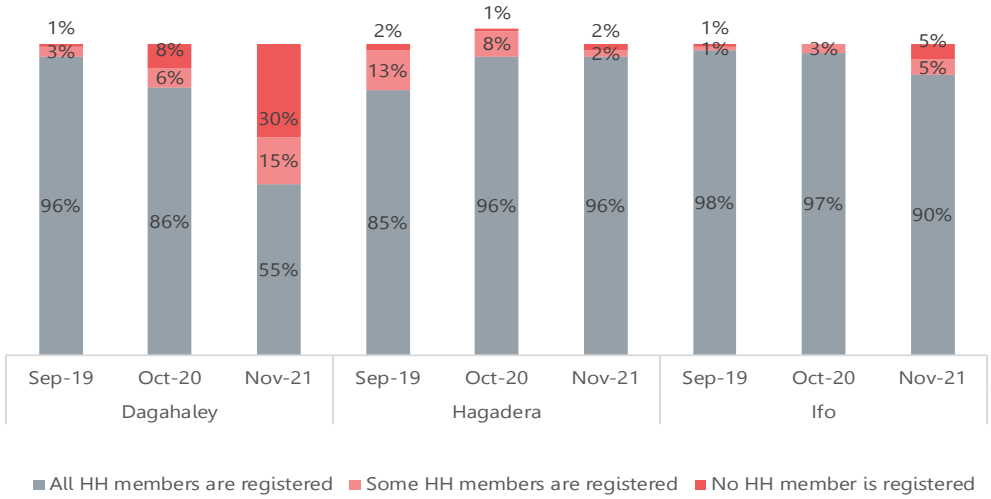
Figure 4: Most commonly reported types of humanitarian assistance received in the 30 days prior to data collection[2]:



PROTECTION

REGISTRATION AND DOCUMENTATION

Figure 5: % of HHs per reported registration status, per round of the MSNA



The proportion of HHs reporting that all or some HH members were not registered as refugees or asylum seekers at the time of data collection, **seems to have increased by 41% and 7% in Dagahaley and Ifo respectively,** between September 2019 and November 2021. Among those HHs who reported that some or all of their members were not registered, the most commonly reported reasons were that **registration was not available** (33%) or that they **had just arrived in the camps** (7%). This finding seems to be triangulated by the fact that the majority of HHs (87%) reported that all or some of their HH members were not registered had been in the country for less than 2 years.

On the other hand, the proportion of HHs that reported about all or some of the HH members not being registered as refugees or asylum seekers in Hagadera seems to have a decreased (4% down from 15% in September 2019).

According to the majority of HHs, community members who are not formally registered were still able to access humanitarian assistance that is freely available to registered refugees and migrants, particularly free health services (80%), education services (74%), WASH services (53%), and food assistance (53%), despite not being registered. That said, some HHs reported perceiving that unregistered HH members experienced particular challenges, such as arrests by security personnel (44%) or reduced access to basic services (24%) (see Figure 6).

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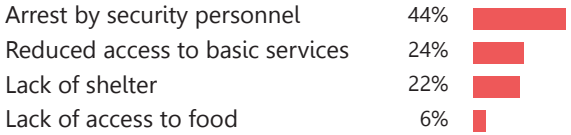
Figure 6: Proportion of HHs reporting challenges experienced by unregistered HH members[2]:



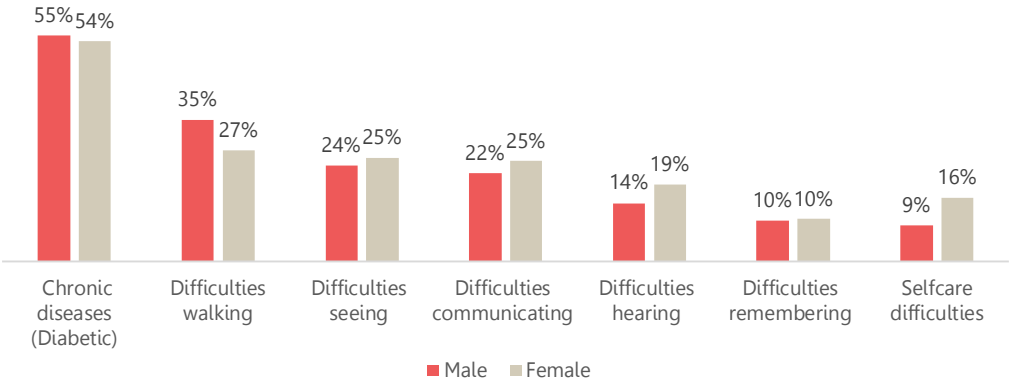
A high proportion of HHs (95%) reported that at least one member of their HH possessed an alien identity card (ID) issued by the Government of Kenya. Other reported identification documents included; Kenyan birth certificates (41%), proofs of marriage (18%) graduation school certificate (9%), and birth certificate from the country of Origin.

Sixty nine per cent (69%) of HHs reported having at least one HH member who was born in Kenya. Of these, 17% reported that **at least one of these members did not have a Kenyan birth certificate** mostly because they had applied but not collected it (64%). Thirty five per cent (35%) of HHs reported that **at least one HH member did not possess a refugee alien card** mostly because they had applied but not collected it (54%) or because it had expired but not yet been renewed (28%).

PERSONS WITH SPECIFIC NEEDS

In November 2021, 38% of HHs reported having at least one member living with a specific need.

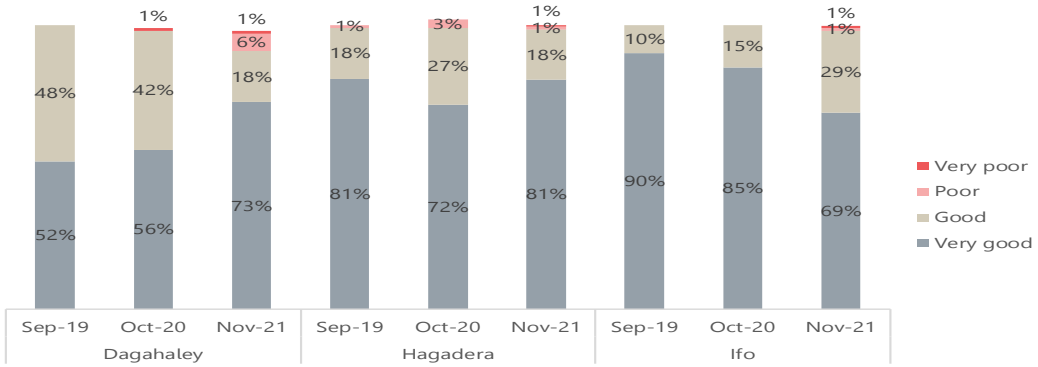
Figure 7: % of HHs reporting having at least one of the following vulnerability profiles among their HH members[6]:



SECURITY

A high proportion of HHs (84%) reported that **women and girls felt unsafe while collecting firewood**. In addition, a considerable proportion of HHs reported that girls in their HH had experienced female genital mutilation (FGM) (22%) and/or forced marriage (16%). Furthermore, seven KIs in Dagahaley and in Hagadera reported that men felt **threatened with violence** and feared **physical violence or harassment** respectively, among other security concerns in the camps.

Figure 8: Proportion of HHs by perception of the security situation in the six months prior to data collection



The majority of HHs (74%) generally perceived the security and safety in the camps to be very good in the six months prior to data collection. This perception seems to have increased in Dagahaley and Hagadera by 19% and 9% respectively between September 2019 and November 2021. Despite this upward trend, **7% of HHs perceived the security status of Dagahaley to be poor or very poor most likely due to threats of violence and harassment as reported by KIs**. On the other hand, Ifo seems to have a downward trend in the proportion of HHs that perceived security to be very good in their camps (69% down from 90% in September 2019). A high proportion of HHs (77%) reported perceiving that it generally takes less than a month for security providers to resolve insecurity cases. Particularly, 69% of HHs who had reported insecurity cases to the community leaders, said that these cases had been resolved in less than one week.

Table 3: Top reported security personnel who the community mostly turned to for reporting security concerns

Security personnel	Proportion of HHs reporting	Number of KIs reporting (of 30 KIs)
Community leaders	69%	19
Police	48%	28
UN officials	17%	3
NGO officials	10%	5

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FOOD SECURITY

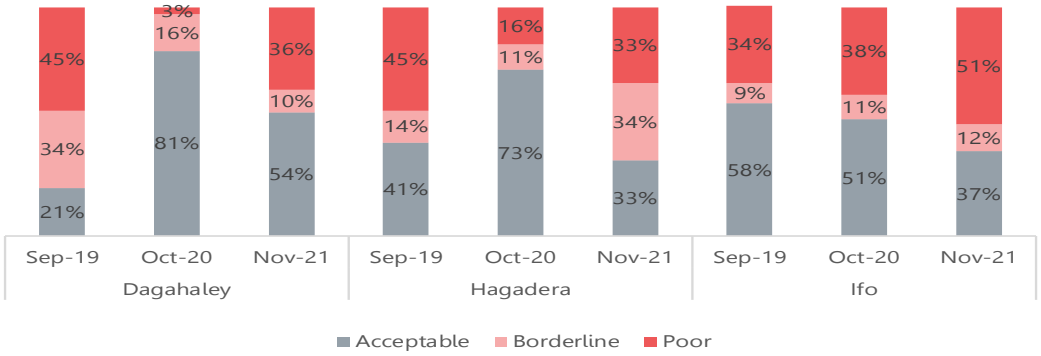
Over half (57%) of HHs in Dadaab refugee complex reported perceiving not having had access to sufficient food for all their HH members in the 30 days prior to data collection. In addition, **98%** of HHs **reported food to be among their priority needs** in the 30 days prior to data collection.

Fifty seven per cent **(57%**) and **10%** of HHs reported **food voucher assistance** and **in-kind assistance** as their primary source of food respectively, indicating that HHs are still commonly relying on unsustainable food sources. In addition, almost two thirds of the HHs (**65%**) reported that the **amount of food supply for their HH had decreased** in the 6 months prior to data collection. These findings were consistent with those from common food security composite indicators; **59% of HHs were found to have a borderline or poor food consumption score (FCS), which seems to be almost double compared to previous round of the MSNA in October 2020**, while about 77% were found to have a low or moderate household dietary diversity score (HDDS), which is the same as in October 2020.

FOOD CONSUMPTION SCORE (FCS)[1]:

The FCS measures how well a HH is eating by evaluating the frequency at which differently weighted food groups are consumed by a HH in the seven days prior to data collection. Only foods consumed in the home are counted in this indicator. The FCS is used to classify HHs into three groups; those with a poor FCS, those with a borderline FCS, and those HHs with an acceptable FCS. Only HHs with an acceptable FCS are considered to most likely be food secure, while those with borderline and poor FCS are considered more likely to face moderate or severe food insecurity, respectively.

Figure 9: Proportion of HHs per FCS, per camp and per round of the MSNA[1]:



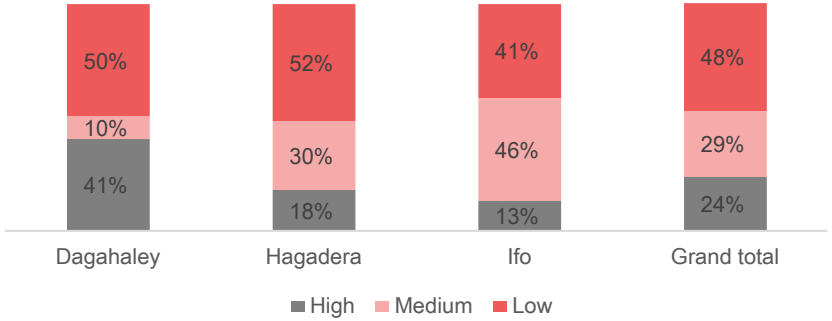
Findings indicate that over half of HHs in Hagadera (67%) and Ifo (63%) were found to have either a **borderline or poor FCS**, indicating that the HHs may be experiencing **various degrees of food insecurity.** In particular, over half of HHs in Ifo (51%) recorded a poor FCS, which was a 13% and 17% increase from the HHs that were found to have a poor FCS in October 2020 and September 2019 respectively.

In Dagahaley, the proportion of assessed HHs that were found to have a poor or borderline FCS increased from 19% in October 2020 to 46% in November 2021. Similarly, the % of HHs with a poor or borderline FCS increased by **40% and 14% in Hagadera and Ifo respectively.** This finding might be linked to the fact almost two thirds of the HHs (**65%**) reported that the **amount of food supply for their HH had decreased** in the 6 months prior to data collection. Generally, findings suggest that a considerable proportion of HHs in Dadaab refugee complex were more likely to face food insecurity as compared to the previous MSNA round of October 2020.

HOUSEHOLD DIETARY DIVERSITY SCORE (HDDS)[1]:

HHs can be further classified as food insecure if their diet is non-diversified, unbalanced and unhealthy. The previous 24-hours' (before data collection) food intake of any member of the HH was used as a proxy to assess the dietary diversity of HHs. The HDDS is used to classify HHs into three groups: high, moderate or low dietary diversity. A high HDDS indicates food security, while moderate and low HDDS suggest moderate and more severe food insecurity respectively. While some variation can be observed between the different camps (see Figure 10), **HHs in all locations were found to commonly have a low or medium HDDS**, suggesting that their diets were likely suboptimal and non-diversified. **Overall, the proportion of assessed HHs that were found to have a low HDDS increased from 27% in October 2020 to 48% in November 2021.**

Figure 10: Proportion of HHs per HDDS, per camp[1]:



More than half of the assessed HHs in Hagadera (52%) and about half in Dagahaley (50%), were found to have a low HDDS, indicating that HH members were likely facing severe food insecurity. Moreover, the **majority of HHs in Ifo (87%) and Hagadera (82%) were found to have either a moderate or low HDDS, indicating that the majority of HH members in these camps were likely facing moderate to severe food insecurity.** This finding can also be linked with that of the poor or borderline FCS in Hagadera, Dagahaley and Ifo which were found to have increased by 40%, 27% and 14% respectively, between October 2020 and November 2021.

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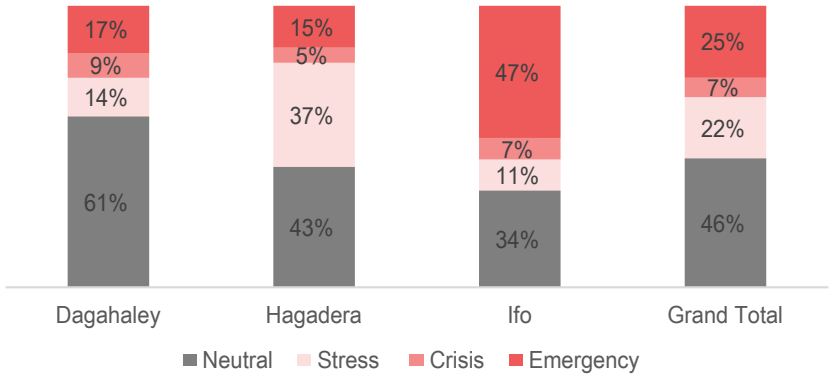
LIVELIHOOD COPING STRATEGY INDEX (LCSI)[1]:

The LCSI is measured to better understand longer-term HH coping capacities. The LCSI is used to classify HHs into four groups: HHs using emergency, crisis, stress or neutral coping strategies to cope with livelihood gaps, in the 30 days prior to data collection. The use of such strategies typically reduces HHs' overall resilience and assets, increasing the likelihood of food insecurity. Findings indicate that **HHs in Ifo (47%) were particularly commonly incorporating emergency-level strategies, suggesting that HHs in Ifo may have been experiencing particularly severe gaps in their ability to meet basic needs.**

Figure 11: Proportion of HHs per LCS score, per camp in the 30 days prior to data collection[1]:



Ifo was found to have the highest proportion of HHs (47%) that were using emergency level coping strategies, suggesting that HHs' overall resilience had decreased in the 30 days prior to data collection. The common use of crisis and emergency-level livelihoods-based coping strategies by HHs in Ifo corresponds to the relatively high proportion of HHs in Ifo found to have a poor FCS (51%) and a medium or low HDDS (87%) and suggests HHs in Ifo were particularly struggling to meet their most basic needs.

In general, **HHs in Ifo (66%) and Hagadera (57%) were found to be using stress, crisis or emergency coping strategies, indicating an increased likelihood of food insecurity.** This finding corresponds to the October 2020 MSNA findings, when over half of HHs in Dadaab were found to be using such coping strategies, indicative of a protracted inability to meet needs, and a reduced resilience, among these HHs. This finding is also consistent with that of the HDDS where **HHs in all locations were found to commonly have a low or medium HDDS**.

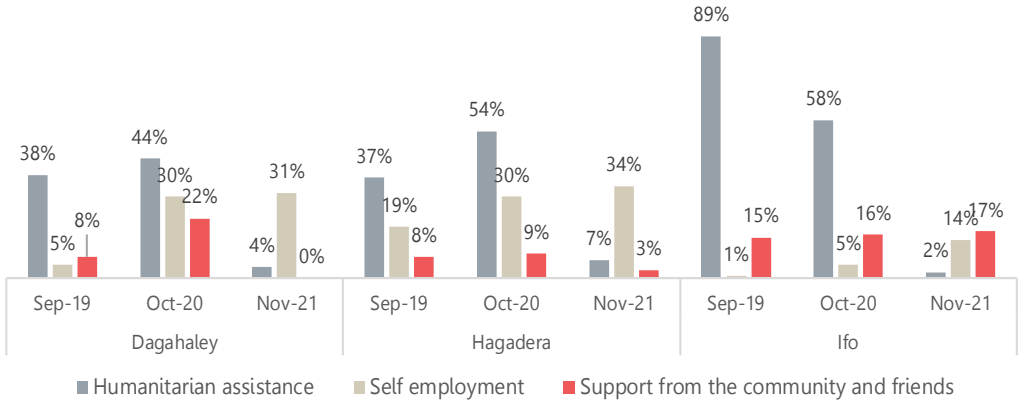
LIVELIHOODS

INCOME

Unlike the previous rounds of data collection, 4% of HHs (down from 52% in October 2020) reported humanitarian assistance as their main source of livelihoods in the 30 days prior to data collection. Similarly, 7% of HHs (down from 16% in October 2020) reported at least on member of their HH receiving support from the community and friends in the 30 days prior to data collection.

KIs reported that some of the most commonly reported sources of income for community members included: livestock farming, humanitarian assistance, formal employment, home-based income generating activities such as sewing, shoe repair, kitchen gardening, among other sources. HH members seemed to have experienced different livelihood barriers due to the impact of COVID-19. Some of the barriers that HH members most commonly reported include; increased prices of commodities (40%), reduced income among HH members (25%) or at least one HH member losing their job as a result of COVID-19 related challenges (18%).

Figure 12: Most common sources of income in the 30 days prior to data collection, reported by all HHs having some form of income[2]:



Findings indicate that the proportion of HHs reporting **humanitarian assistance as their source of income significantly decreased in all the camps**. In particular, the proportion of HHs reporting humanitarian assistance as their source of income in Ifo decreased from 89% in September 2019 down to 2% in November 2021.

On the other hand, **HHs that reported self employment as their source of income seems to have increased in all the camps between October 2019 and November 2021.** The proportion of HHs that reported self employment as their source of income increased by 26% in Dagahaley, 15% in Hagadera and 13% in Ifo between October 2019 and November 2021. These findings suggest a more sustainable livelihoods engagement among HHs in the camps.

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Forty three percent of HHs (43%) reported having at least one member of their HH operating a business in Dadaab. Among these HHs, 31% reported having borrowed money from friends and/or relatives to start their businesses, **62% reported having spent their savings to set up their businesses,** and 5% reported that they had received start-up grants from the UN. Of the HHs that reported having a business, **44% reported that they did not have a business permit for their business**. A considerable number of KIs reported that the most commonly run businesses in Dadaab camps were **food retail shops (22), tailoring shops (19), salons (15) and mechanic shops (5)**. KIs reported that the business owners had received business trainings from humanitarian actors in Dadaab. However, KIs reported that business owners often lack access to loans and funds to restock their business and that there are particular laws that are unfavourable for businesses.

VOCATIONAL TRAINING AND EMPLOYMENT

Twenty three percent (23%) of HHs reported having at least one member who had attended vocational training in the 6 months prior to data collection. The majority among these HHs reported that at least one female or male member had completed the training (81% and 77%, respectively). **A high proportion of the HHs (88%) that reported HH members had completed vocational training reported that the skills acquired were sufficient** (i.e. members could use those skills to earn an income).

Thirty eight percent (38%) and 46% of HHs reported having at least a male and female HH member respectively, who had attended vocational training but was not using the skills and knowledge acquired in training at the time of data collection. Among HHs with male and female members who were reportedly not using their skills acquired in vocational training, 38% and 55% respectively, attributed this to there not being any jobs available to them.

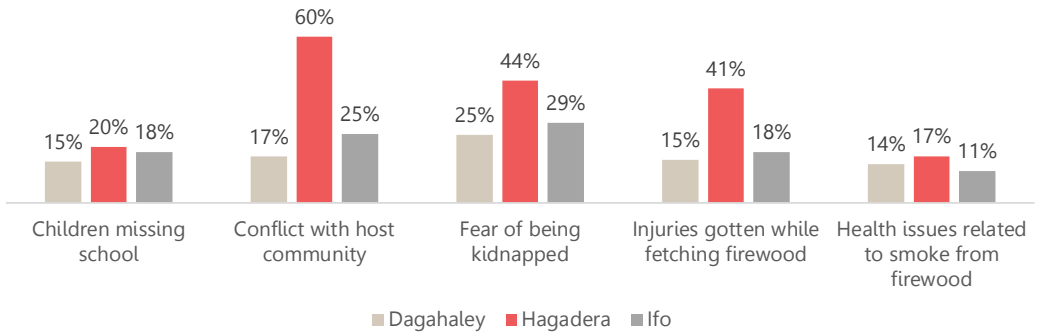
KIs reported that the most common barriers to accessing employment encountered by the vulnerable groups[3] were: lack of skills that match job requirements, lack of capacity to perform job among persons with disabilities, lack of social connections, and discrimination because of disability or age among other barriers.

ENERGY

Forty percent (40%) of HHs reported **that their main source of lighting was electricity** at the time of data collection.

A high proportion of HHs (92%) reported firewood and 7% reported charcoal to be their main source of heat for cooking. However, while it provides heat and allows cooking, findings suggest firewood creates challenges for HHs, such as perceived tensions with the host community, fears of being kidnapped, and injuries related to firewood collection.

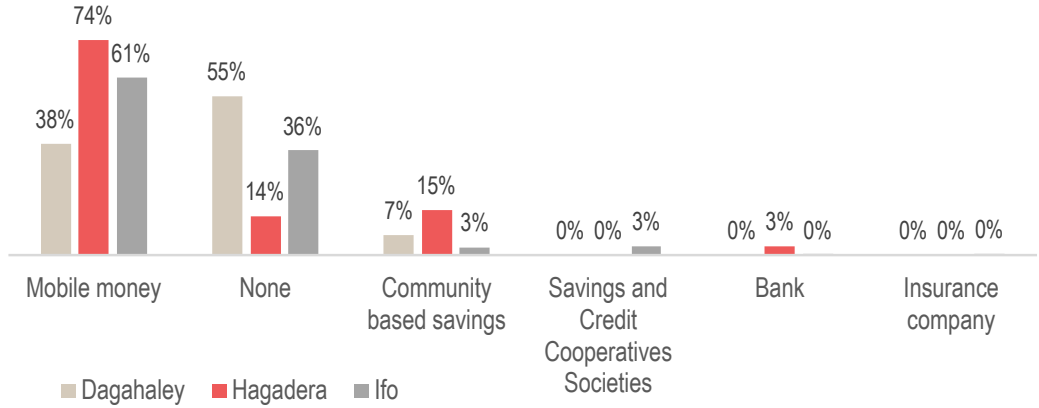
Figure 13: Most commonly reported challenges faced while fetching or using firewood[2]:



FINANCIAL INSTITUTIONS

The availability and access to financial institutions is a key part of HHs' livelihood. The proportion of HHs that reported having access to mobile money decreased from 81% in the October 2020 round of MSNA to 59% in November 2021. Furthermore, a considerable proportion of HHs, particularly in Dagahaley (55%), reported not having access to any type of financial institution.

Figure 14: Proportion of HHs that reported having access to the following financial institutions[2]:



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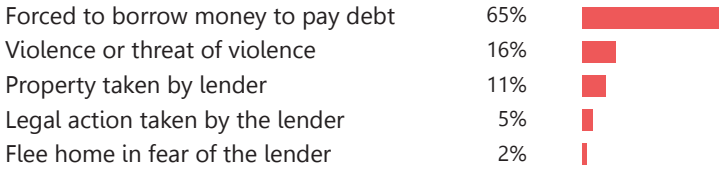
HOUSEHOLD DEBT

A relatively high proportion of HHs (76%) reported having borrowed some money from family, friends, traders, etc. at the time of data collection. **Of these, 81% reportedly borrowed the money to buy food**, 31% borrowed money to meet other basic HH needs and 25% borrowed money to pay for health care.

Figure 15: Top reported consequences experienced by HH members who had debts in the 3 months prior to data collection[2]:



EDUCATION

Among all school-aged boys and girls in the assessed HHs, a higher proportion of boys (51%) and girls (57%) in Ifo than in Dagahaley and Hagadera were reportedly not attending school in the 12 months prior to data collection. The top reported reason for school-aged children not attending school is that parents or guardians perceive their children to be too young to attend school. HHs where parents or guardians perceived school-aged children to be too young to attend school cited that they preferred their children to attend Madrassa[5] first.
A higher proportion of children were reportedly attending primary school in comparison with those attending secondary school **which suggests that a considerable number of children are not transitioning to secondary school after completing primary school**. Moreover, over half (54%) of the HHs reported that no child in their HHs attended any kind of informal education, in the 12 months prior to data collection.

Furthermore, 15% of HHs reported that they had at least one member of their HH who did not transition to tertiary education after completing secondary school in the five years prior to data collection. The top reported barriers for these HH members not transitioning to tertiary education were the inability to pay for school fees and stationary, a lack of motivation because those who attended tertiary education are still in the camps and others are without jobs and prefer to work instead.

Figure 16: % of HHs with school-aged[10] boys in their HHs, per amount of school-aged[10] boys reportedly attending school (ECD[7], primary, and secondary) in the 12 months prior to data collection

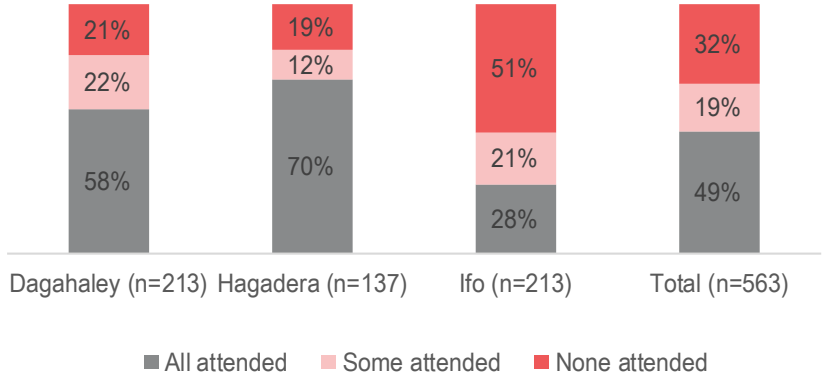
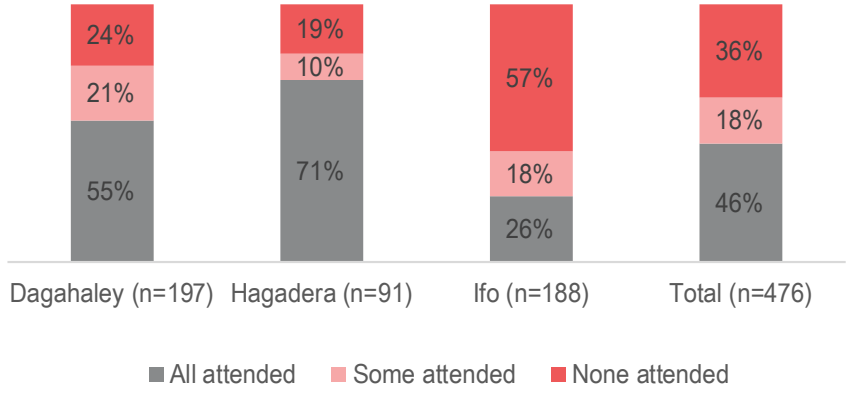


Figure 17: % of HHs with school-aged[10] girls in their HHs, per amount of school-aged[10] girls reportedly attending school (ECD[7], primary, and secondary) in the 12 months prior to data collection



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WATER, SANITATION & HYGIENE (WASH)

WATER

In general, 45% of HHs **reported not having access to adequate water to meet their HH's needs** in the 7 days prior to data collection. Of these, 32% reportedly reduced the consumption of water for hygiene practices while 10% fetched water at another water point further away in order to cope with a lack of enough water.

All KIs reported that the main source of water for the community was public tap stands. Only KIs in Hagadera reported that the community was experiencing challenges in accessing water. Despite reportedly having access to sufficient water, half of the HHs reported that members of their HHs experienced challenges while fetching water. The top three reported challenges were **long waiting/queueing time (46%), lack of enough water at the source (37%) and lack of enough storage containers (22%).** Sixteen percent of HHs (16%) reported walking for over 30 minutes to fetch water. In addition, 34% of HHs reported having to wait for over 30 minutes for their turn to fetch water at the water points.

HYGIENE & SANITATION

A considerable proportion of HHs (19%) reported not having soap at the time of data collection, the majority among whom (80%) reported that they were waiting for the next distribution, while 24% reported not being able to afford soap

At the time of data collection, a majority (81%) of HHs reportedly had soap. In addition, almost all of the HHs (99%) reported washing their hands at all, or some critical hand washing occasions[4].

Almost all HHs (98%) reported having access to a sanitation facility. The most commonly reported sanitation facility used was a pit latrine (54%). Among those HHs using pit latrines, 11% reported sharing their latrine with other HHs. Moreover, 87% of HHs reported that the shared sanitation facilities did not have separate stalls for women, which was also commonly reported by KIs. KIs also disclosed that **sanitation facilities did not have sufficient privacy and that they were often unclean and overcrowded, hence exposing users to risk of contracting diseases**. A considerable proportion of HHs (61%) reported experiencing challenges related to access to sanitation facilities.

Figure 18: Top reported challenges related to accessing sanitation facilities, as reported by a proportion of HHs[2]:

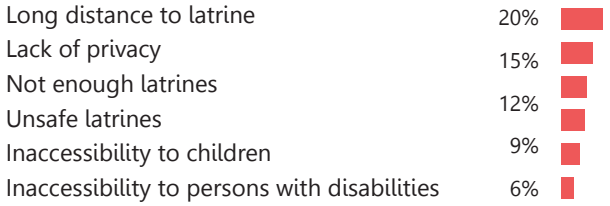
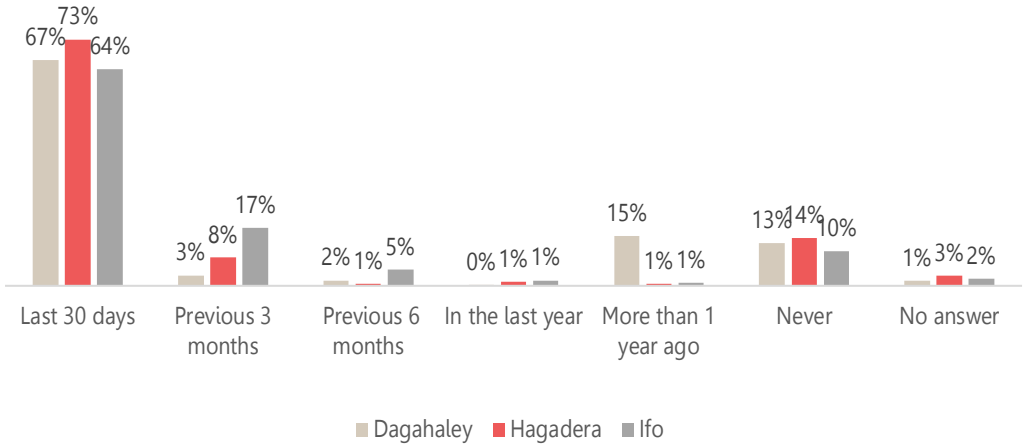


Figure 19: Proportion of HHs reporting members had received hygiene promotion messages in the following timelines



HEALTH

Fourteen percent (14%) of HHs reported that at least one member of their HH had a health problem and needed to access health care, in the 3 months prior to data collection. **Of these, 96% reported that at least one HH member was not able to access health care**. In addition, over half (55%) reported that they would seek care from an NGO-run hospital, while 25% reported they would go to a clinic, with some variation by location (see figure 20). Furthermore, 18% of HHs reported having paid for health services such as consultation, treatment or medicines, of which **37% reported not being satisfied** with the health care received.

A high proportion of HHs (92%) reported that it takes them less than one hour to reach the health facility that is nearest to their homes. Moreover, **a majority of HHs (90%) reportedly walked on foot to the nearest health facility.**

More than half of the HHs (52%) in Dadaab refugee complex generally perceived that their HHs will not experience any barriers if they were to need to access healthcare (Figure 21).

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Figure 20: Top reported health facilities that HH members sought health care from, as reported by a proportion a of HHs[2]:

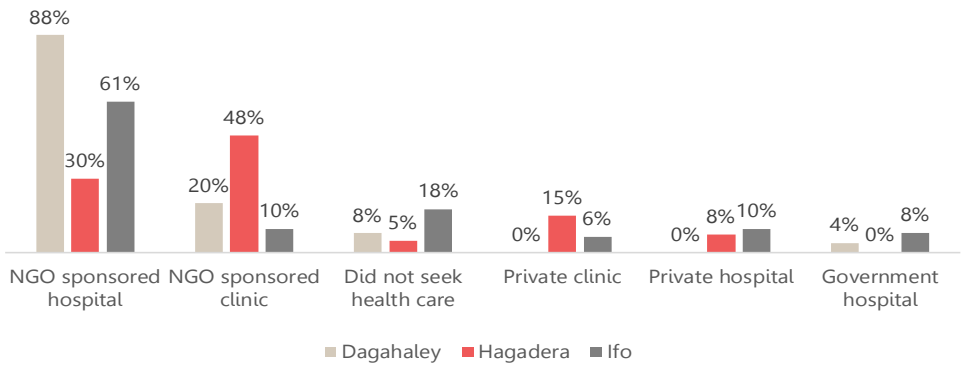


Figure 21: Top reported perceived barriers to accessing healthcare, by proportion of HHs[2]:

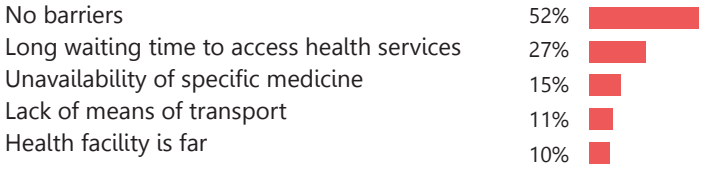


Figure 22: % of HHs per camp, per amount of children aged 12-23 months in their HH, that had reportedly received DTP[8] vaccine at the time of data collection

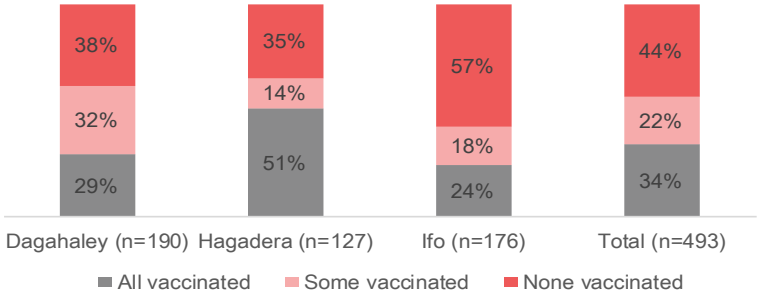


Figure 23: % of HHs per camp, per amount of children aged 9-59 months in their HH, that had reportedly received measles vaccine at the time of data collection

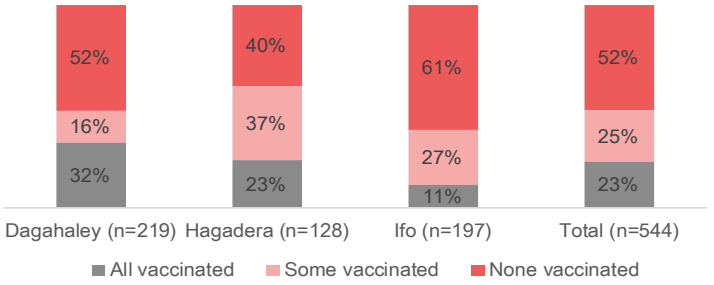


Figure 24: % of HHs per camp, per amount of children aged 6 or younger in their HH, that had reportedly received polio vaccine at the time of data collection

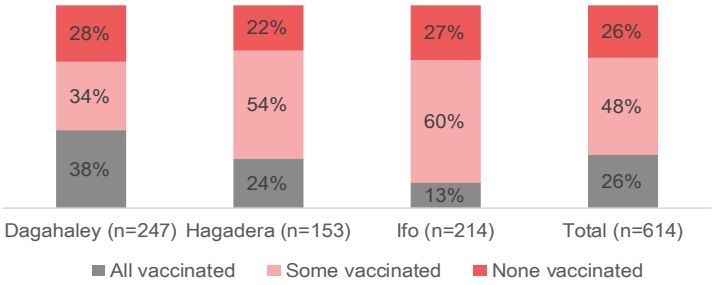
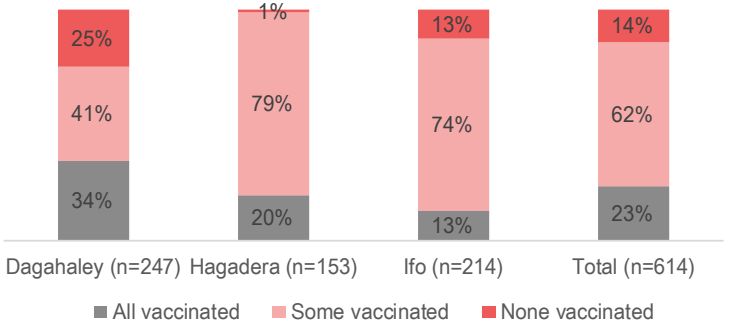


Figure 25: % of HHs per camp, per amount of children aged 6 in their HH, that had reportedly received BCG[9] vaccine at the time of data collection



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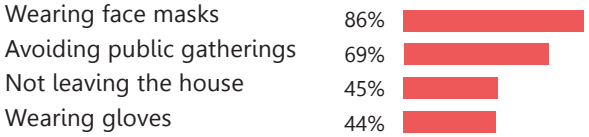
COVID-19

About a third (31%) of HHs reported not having received any information about COVID-19 in the 12 months prior to data collection. Among those HHs who reported having received COVID-19 information, the most commonly reported sources of this information were radios and televisions (66%), word of mouth (34%), and directly from health workers (31%). Two per cent of HHs reported having lost at least one HH member to COVID-19 or COVID-19 related complications in the 12 months prior to data collection.

The majority of KIs reported that the community had received information about how to prevent the spread of COVID-19, COVID-19 vaccination, and the effects of COVID-19 in the 12 months prior to data collection. Moreover KIs reported that the community mostly trusted health workers, NGO staff and community leaders to provide them with reliable COVID-19 information.

Overall, 41% of HHs that were found to have school-aged children[10] reportedly faced barriers in accessing education as a result of COVID-19 in the 12 months prior to data collection. Among these, 28% commonly reported schools being closed as their main barrier. In addition to education access barriers, 25% of HHs reported facing barriers meeting their livelihoods needs, mostly because **the price of commodities had increased, their income had reduced or they had lost jobs.**

Figure 26: Top reported actions taken by HHs members to prevent contracting COVID-19[2]:



CONCLUSION

Findings suggest that despite receiving humanitarian assistance, HHs in Dadaab refugee complex continue to face challenges in meeting their humanitarian needs accross multiple sectors. One of such sectors is food security, with almost all HHs (98%) reporting food as a priority need, a finding that is similar to the previous rounds of the MSNA in Dadaab. In addition, 76% of HHs reported having borrowed money from friends or relatives, of whom **87% reported spending the money on buying food. Fifty-nine percent (59%) of HHs, up from 31% in the October 2020 MSNA were found to have either a poor or borderline FCS. Fifty-four percent (54%) of HHs were using either emergency, crisis of stress level livelihood-based coping strategies**, which reduce HHs' overall resilience and assets, in turn increasing the likelihood of food insecurity.

Findings also indicate that documentation and access to information on how to obtain it, remains a challenge for some refugees in Dadaab refugee complex. **About a third (35%) of HHs reported that at least one HH member did not possess a refugee alien card, mostly because they had applied but not collected it or it had expired but not yet been renewed.** Findings suggest those without proper documentation are exposed to different challenges, such as risk of arrests and limited access to services and assistance.

Aditionally, findings suggest that vulnerable groups[6] in Dadaab refugee complex faced security concerns and experienced difficulties in accessing essential services. In particular, women and girls reportedly felt unsafe **while collecting firewood, which was identified by (92%) of HHs to be their main source of heat for cooking.** Furthermore, KI findings suggest that HHs with persons living with disabilities and low income HHs were facing heightened barriers in accessing different services within the camps.

End notes

1. For more information on food security indicators (FCS,CSI, HDDS) please see here:
2. Households could select multiple answers
3. Vulnerable groups are persons within the camps that have specific characteristics that make them at a higher risk of needing humanitarian assistance than others.
4. According to the WASH Cluster, hand washing should happen at 5 critical times i.e. before touching food (eating, preparing food or feeding a child) and after contact with excreta (after using the toilet or cleaning a child's bottom).
5. Madrassa classes offer basic knowledge in Islamic education such as recitation of Quran, Hadith, Seera, Lugha, Khati, Fighi, and Hisab.
6. Vulnerability profiles are based on the Washington Group Guidance. For more information, please see here.
7. Early childhood education (ECD).
8. DTP vaccine is a class of combination vaccines against three infectious diseases in humans: diphtheria, pertussis, and tetanus.
9. Bacillus Calmette–Guérin (BCG) is a vaccine primarily used against tuberculosis.
10. Children are considered to be of school age when they are between 4 and 17 years old. In this age category, 963 boys and 734 girls were reported on.

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